Clear Form

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND ("EUTF")

Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement

- ✓ I request reimbursement for my Medicare Part B Premium. A copy of my Medicare card is attached (for initial requests only).
- ✓ I certify that my Medicare Part B premiums are not paid by any other entity, e.g. the Medicare Savings Program or Medicaid. Should my Part B premiums be paid by another entity in the future, I will notify the EUTF within 30 days of being notified by the other entity.
- ✓ If my enrollment in Medicare Part B stops I will notify the EUTF within 30 days. I understand that disenrollment from Medicare Part B means I will no longer be eligible for Part B premium reimbursement, as well as medical and prescription drug coverage.

Retiree's Name:		**SSN or EUTF ID Number:**
Retiree's Mailing Address:		**Phone:**

SECTION A – Deposit Authorization

Hawaii law (Act 039, SLH2006) requires all individuals who become eligible for Medicare Part B reimbursements on or after July 1, 2006 to designate a financial institution account into which the State of Hawaii EUTF shall be authorized to deposit their quarterly Medicare Part B reimbursements.

By signing in Section D, I/We hereby authorize the State of Hawaii EUTF to automatically and directly deposit my Medicare Part B premium reimbursements to my/our account at the financial institution named below:

SECTION B – Account Information (see your financial institution for help in completing this section)

Name of Account Holder(s):		
Name of Financial Institution:		
Routing Number:		
Account Number:	☐ **Checking***	☐ **Savings**
Financial Institution Certification (Required for Savings; Optional for Checking):		
Name of Agent:_____	**Phone:**_____	
Signature:_____	**Date:**_____	

SECTION C – Agreements of <u>All</u> Account Holders

By signing in Section D, the Account Holder(s):

- Certify all information is accurate and authorize the EUTF to make withdrawals from my/our account in the event that the EUTF benefits have been deposited to the account in error, e.g., overpayments.
- Consent to the disclosure by the Financial Institution to the EUTF of any information that the EUTF requests to effectuate, administer, or enforce the transactions authorized in Sections A and C.
- Agree not to hold the EUTF responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me/us or by Financial Institution or due to an error on the part of Financial Institution in depositing funds to the account.

SECTION D – Signatures of All Account Holders

Authorized Signature (Primary):	**Date:**
Authorized Signature:	**Date:**

***Please attach a VOIDED check and return this form to the EUTF**

Instructions for Medicare Part B Reimbursement Request and Direct Deposit Agreement Form

The 2006 State Legislature passed Act 39 which was signed into law by the Governor on April 27, 2006. The act establishes the requirement for all individuals who become eligible for Medicare Part B reimbursements on or after July 1, 2006 to designate a financial institution into which the EUTF shall be authorized to deposit their Medicare Part B reimbursements.

All portions of the Direct Deposit Agreement must be completed, except where optional, in order for the form to be valid. In addition, if there is any alteration of this form, a new form must be completed.

You must submit a new form if there are any changes to your account (i.e., account number, account holder, financial institution). The most recently dated form submitted to EUTF will apply.

Section B – Account Information
The name of the retiree or surviving spouse name must appear on the account. You may ask the representative of the financial institution to help complete this section. For deposits into a savings account, Financial Institution certification is required. For checking accounts, the certification is optional, but a voided check must be attached.

Section C – Agreements of All Account Holders
This section contains the agreements of <u>everybody</u> who is on the account, including the EUTF retiree or spouse or domestic partner or civil union partner. <u>The agreements in Section C apply to all Account Holders even if they are not the retiree or spouse receiving Medicare Part B reimbursements.</u>

Section D – Signatures of All Account Holders
By signing the Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement, the retiree, spouse, and/or surviving spouse certify the information is accurate and confirms that they understand and agree to the agreements in Section C.

The retiree or surviving spouse signs as primary account holder. If the account is a joint account, please have all account holder(s) sign the form. Use an additional sheet if necessary. If you are representing the retiree or surviving spouse or surviving domestic partner or civil union partner, please ensure that you have any authorizing document(s) attached to the Direct Deposit Agreement.

Please be sure to attach a VOIDED check if depositing into a checking account or have the financial institution complete Section B, if depositing into a savings account and return this form to the EUTF.

If you have any questions, please contact the EUTF customer call center at

Oahu: (808)586-7390
Toll-free: (800)295-0089

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